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NEW POLICY--EFFECTIVE DATE: APRIL 1, 1985

Section 263.3 Determining Denial Rates for HHAs has been revised. The former instructions required that all cases be reviewed to calculate the denial rate. These instructions recognize that it may be necessary to reduce the volume of cases to be reviewed under certain circumstances. The imposition of fiscal constraints, shifts in program emphasis, or fluctuations in workloads or review findings may dictate that less than 100% of an HHA's bills be reviewed. In such instances, the data collected for waiver of liability purposes will be obtained only from the cases reviewed.

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Where an HHA meets the criterion (see §§ 263ff.), all of its claims for Part A and B home health agency visits will be processed under the presumption that it had no knowledge of noncoverage unless the evidence in a particular case shows that, in fact, it had such knowledge. When an HHA does not meet the criterion, the presumption is not applicable and the HHA's liability will not ordinarily be waived in cases denied as not reasonable or necessary. However, even though an HHA has been found not to meet the criterion, and a presumption cannot be extended to its cases, the HHA may allege that in an individual claim it did not know and could not have been expected to know that the care could not be covered. In such situations, the intermediary will consider the evidence submitted in support of the allegation.

The presumption applies to all categories of claims. Distinctions will not be made by category, except that when an HHA has been advised either by intermediary bulletins or by denial of a prior claim that a specific modality of services that it renders is not considered reasonable and necessary, claims for that type of service cannot be entitled to the presumption. See §§ 268ff. for discussion of waiver of liability for Part B provider services billed on HCFA-1483.

B. Provider Is Determined to Be Liable--Right to Appeal.-- A provider who is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by an intermediary under certain conditions (see §256).

NOTE: The waiver of liability provision does not apply to third party payors. Therefore, a provider who is determined liable may seek payment from a third party payor without being subject to recovery action that could occur if it sought payment from the beneficiary.

C. Provider and Beneficiary Determined to Be Without Liability.-- If the intermediary determines that neither the provider nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment. (See § 267.)

With respect to the beneficiary, the instructions contained in §§ 260-268.4 will apply in determining waiver of liability.

263. CRITERIA FOR PRESUMING THAT HHA MEETS WAIVER OF LIABILITY REQUIREMENTS

To determine whether an HHA has knowledge of Medicare coverage rules and can apply them, intermediaries will collect statistics to ascertain whether each HHA's denial rate does not exceed 2.5 percent (see § 263.3 for determining the HHA's denial rate.).

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For purposes only of determining an HHA's presumptive waiver of liability status, compliance with the following criteria are deemed met if the HHA meets its applicable denial rate: (1) the certification/recertification requirements in 90 percent of the cases reviewed; (2) procedures that assure that bills and medical documentation are submitted in a timely manner; and (3) procedures which assure timely HHA notice to beneificares.

263.1 Reevaluating and Notifying HHA's-- Each HHA must be reevaluated at least every 3 months to determine whether it is entitled to a favorable waiver presumption. The intermediary may set a shorter time for reevaluation in special situations where an HHA or a group of HHAs has drastic fluctuations in its denial rates.

The intermediary is to notify the HHA in writing when there is a change in its presumptive status.

263.2 Reevaluating HHA's Presumptive Waiver of Liability Status for a Prior Period.-- Occasionally, new information may indicate that an earlier determination that a HHA qualified for presumptive waiver of liability status was erroneous. In such a situation, the intermediary may retrospectively reevaluate and redetermine the HHA's compliance with the requirements for a favorable waiver presumptive for a prior period.

If the reevaluation of the HHA's compliance so establishes, the intermediary may determine that the HHA had, or could reasonably have been expected to have had knowledge of the noncoverage of the services for claims denied as not being medically reasonable and necessary during the prior period in question.

Even though the intermediary determines after reevaluation, the HHA was in compliance with the appropriate denial rate criterion, it may rebut the HHA's favorable presumption in any individual case in which the evidence is clear and obvious that the HHA should have known at the time the services were furnished that they were not covered.

263.3 Determining Denial Rates for HHA's.-- Specified data will be recorded for each HHA for those cases reviewed in which a Medicare beneficiary receives services prior to an event terminating program coverage. Terminating events include: (1) HHA notice; (2) intermediary notice; (3) exhaustion of benefits; (4) discharge; or (5) death.

The intermediary records the following data:

A. All visits (excluding "grace day" visits under § 1879) determined by the HHA to be covered. All visits will be considered to have been determined covered by the HHA if they are billed as covered by the HHA or if they were incurred prior to a terminating event.

B. All visits determined by the HHA to be covered but determined by the intermediary to be noncovered because the services provided were not medically necessary and reasonable.

NOTE: Visits denied for other reasons than Sections 1862(a)(1) or (9) should not be included in either A. or B..

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The denial rate is calculated by dividing "A" into "B." For the denial rate criterion to be met the number of visits in "B" must not exceed 2.5 percent of the number of visits in "A."

263.5 Time Period for Calculating HHA Denial Rate.-- Each calendar quarter, or more frequently if it is believed necessary, the intermediary calculates each HHA's denial rate based on the data collected for that HHA during the preceding calendar quarter. The denial rate will be calculated by the end of the month following the end of the quarter.

For example, data compiled during 1/1 through 3/31 is used to calculate the HHA's denial rate. This calculation is made by 4/30. If shorter time, e.g., 1 or 2 month periods are used, the principles above are adapted to the shorter times.

263.6 Effect of Changes in HHA Waiver Status.-- Intermediaries will advise the HHA of any changes in its waiver status by the end of the month following the end of the quarter for which the denial rate was calculated.

For example, if there is a change in a HHA's status based on data complied from 1/1 through 3/31, the HHA retains its former presumptive status for services rendered from 1/1 through 3/31 and up to the date of the intermediary's notice of change of presumptive status, but no later than the last day of the month following the end of the quarter (in this case 4/30).

All claims processed involving services on or after the date of notice will be processed under the new presumptive status.

263.7 Treatment of Visits Initially Denied But Later Reversed.-- Visits initially denied as noncovered but later determined to be covered, i.e., as a result of a reconsideration, hearing, or reopening and revision are to be subtracted from the provider's denied Medicare visits. The subtracting of such visits will be applied to the period during which the reversal action occurred.

NOTE: Visits payable only under the waiver of liability provision are considered noncovered visits and would not be counted as covered in the denial rate calculations.

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